

Anne D. Bartolucci, Ph.D., C.B.S.M.

Psychological Services Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and be sure to let me know if you have any questions **at the first session**.

PSYCHOLOGICAL SERVICES:

During our first few sessions, you and I will discuss what brought you to therapy. These sessions will typically include informal (unstructured) assessment. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise.

A few things to remember:

- Psychotherapy is not like a medical doctor visit. It calls for a very active effort on your part. You will likely have "homework" to complete between sessions.
- Sometimes undesirable behaviors increase in intensity before they lessen when you start addressing them. This is normal and usually temporary.
- The benefits of psychotherapy outweigh the risks, but there are no guarantees of what you will experience.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality.
- I have contracts with Medical Billing Associates. As required by HIPAA, I have a formal business associate contract with this business, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
- If I determine that a patient presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

Anne D. Bartolucci, Ph.D., C.B.S.M.

The following information pertains to my financial policy. I hope this will answer any questions you may have, but if you have any questions or special concerns please do not hesitate to discuss them with me **at the first session**. Please acknowledge your understanding of this policy by signing at the end of this form. If you would like a copy of this form for your records I will be happy to provide one for you.

1. My fee is \$150.00 per therapy hour for individual sessions, \$165.00 per therapy hour for group or family sessions, **payable at the end of each session**. The usual therapy hour consists of 45-50 minutes. Group therapy hours may last as long as 60-75 minutes. The fee for the initial diagnostic session is \$185.00. Additional fees may be incurred for psychological testing, but I will discuss these ahead of time with you. Charges for consultations outside the usual therapy hour (i.e., hospital visits, depositions, etc.) will be determined on an individual basis.

2. Payment is expected at the end of each session. **Please discuss exceptional circumstances with me at the first session**. Visa and MasterCard are accepted for your convenience. Please note that I am in-network for the following managed care plans: Aetna, Blue Cross/Blue Shield, ComPsych, Humana/LifeSynch, Medicare, and Tricare. *Please note that sometimes insurance companies contract out their mental health benefits to other carriers*. If your insurance company is not listed, feel free to explore out of network benefits for your insurance company. If payment in full for my services is a hardship for you, we can discuss a payment plan.

3. Since your appointment time is reserved for you, please notify me as soon as possible if you find that you must cancel an appointment. **Appointments not canceled with at least 24 hours notice will be billed at the usual fee of \$150.00. Monday appointments must be canceled by 12:00 noon the Friday before to avoid charges.** It is important to note that insurance companies do not reimburse for missed or late canceled sessions, so the full \$150.00 fee will be your responsibility.

I acknowledge responsibility for all fees incurred, and if it is necessary, I consent to have my account collected through an attorney or collection agency. I also agree that I will be responsible for all costs of litigation including attorney's fees. I have read and understand the above policies.

Patient's Signature

Date

Parent or Guardian's Signature of minor

Important Information for Insurance Patients

Insurance Patients: Please read the following information and sign the Agreement at the bottom of this page if you would like me to file insurance for you.

Health Insurance Coverage

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Despite our best efforts in determining your coverage, it is very common for insurance companies to pay differently than what they quoted you at the time of the first visit, deny coverage at a later date, or request a refund for funds previously dispersed. For that reason, you may receive a bill for services rendered if your insurance company does not reimburse as anticipated or requests a refund for previously paid services.

Authorization for Treatment

Many insurance plans require authorization before they provide reimbursement for mental health services. This authorization is typically required prior to or on the day of the first session. My office will do everything we can to acquire authorization on the first day of treatment, but, ultimately, it is the patient's responsibility to contact the insurance company for authorization. If the correct information is not provided at the first appointment, then this will likely delay the authorization process. Insurance companies rarely back-date authorizations, so the initial appointment and subsequent appointments may not be covered until authorization is obtained. Insurance carriers often limit the number of sessions authorized at a time. I am willing to complete any paperwork necessary to request authorization for more sessions, but *it is your responsibility to notify me of when your sessions are about to expire so I may request more without any gap in coverage. Failing to do so may result in your being billed for any sessions not covered.*

Insurance Reimbursement

You should also be aware that your contract with your health insurance company requires that I provide them with information relevant to the services that I provide to you. **I am required to provide a clinical diagnosis for reimbursement.** Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will be in a database. I have no control over what they do with this information once it is in their hands. In some cases, they may share the information with a national medical information databank, which may affect your health insurance premiums, ability to acquire an individual insurance policy, or life insurance eligibility and premiums. I will provide you with a copy of any report I submit, if you request it. If you have any questions about this information, please let me know at the beginning of the first session. By signing this Agreement, you agree that I can provide requested information to your carrier.

Assignment of Benefits

I authorize Dr. Anne Bartolucci to release any medical, diagnostic, or other information necessary for the processing of insurance claims. I authorize payment of medical benefits to Dr. Anne Bartolucci for services rendered. I accept personal responsibility for any balance remaining for services rendered including those that may be determined "not medically necessary" by my insurance carrier or denied coverage for any reason. I may receive a bill for services rendered if my insurance company does not reimburse as anticipated or requests a refund for previously paid services. I acknowledge responsibility for all fees incurred and accept responsibility for payment in full. If it is necessary, I consent to have my account collected through an attorney or collection agency. I also agree that I will be responsible for all costs of litigation including court and legal fees.

Patient/Parent or Guardian Signature

Date

Primary Care Physician Information:

Name _____

Address _____

Phone _____

How long have you been a patient of this physician? _____

For purposes of continuity of care, may we contact your physician to let him/her know of your visit?

Yes ___No___

If yes, I _____ give permission to _____
to send a general statement notifying my primary care physician of my visit today. The information sent will be used for coordination of care, and will be limited to a brief description of the problem area and/or diagnosis, and a general outline of treatment.

Patient Signature

Date